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# **Tyler DeLeon**

## **Fatality Review**

### **Department of Social and Health Services Children's Administration**

**January 2006**

#### **Child Fatality Review Committee Members:**

Debbie Regala, Committee Chair, Washington State Senate  
Shari Gasperino, Co-Chair, CASA/GAL Program Coordinator, Benton-Franklin Superior Court

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## **Scope of Executive Fatality Review**

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Given its limited purpose Child Fatality Reviews facilitated by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

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## Executive Summary

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In October 2005, Children's Administration (CA) convened a multi-disciplinary fatality committee to review the practice and events that occurred prior to the death of 7-year-old Tyler DeLeon in January 2005. The purpose of this review was to evaluate the department's delivery of services to the family, as well as the system response to the needs of the family.

The review committee consisted of professionals from the community and from within CA, who represented disciplines associated with services provided to the family over several years. Participants included: a pediatrician, an educator, a mental health professional, a representative from the Guardian ad Litem (GAL) program, a police chief, a foster parent, two legislators and two department representatives from the Division of Licensed Resources (DLR) and Division of Children and Family Services (DCFS).

The committee reviewed CA case file information and medical and school records. They interviewed a total of 14 individuals who had direct information about the DeLeon family or provided consultation about the case. Those individuals included: CA social workers, school personnel, a physician, a psychologist and an assistant attorney general.

The review focused on the DeLeon case, and the findings are specific to it. Documents reviewed by the committee included:

- Chronology of significant events in Ms. DeLeon's home before and after she became a foster/adopt parent
- Division of Licensed Resources/Child Abuse and Neglect Section (DLR/CPS) investigations that identified Ms. DeLeon and her adult daughter, Christina Burns, as subjects
- Documents from the Office of Foster Care Licensing (OFCL)
- Documents from the adoption support record
- Medical records for Tyler DeLeon and other children who had lived in Ms. DeLeon's home
- Analysis of the children's medical records conducted by Dr. Naomi Sugar, a pediatrician who specializes in child abuse and neglect cases
- *A Systems Approach to Investigating Child Abuse Deaths*, an article by Eileen Munro
- References on Psychosocial Dwarfism, a form of failure to thrive caused by emotional deprivation
- Previous CA fatality reviews regarding Lauria Grace, Zy'Nyia Nobles and Rafael Gomez

The committee found that Tyler DeLeon's case was remarkable because there were so many professionals involved with his physical, emotional and psychological care and no one realized the extent of the peril he was in at his adoptive home. His history reflects a pattern of injuries and food and water deprivation. Unlike more "typical" neglect cases, Tyler's foster/adopt mother regularly took him for medical care and interacted with medical providers and school authorities. She was the primary source of information for the professionals involved in Tyler's life and seemed to have plausible explanations for his injuries and health problems. Most of the professionals believed Ms. DeLeon was honest and credible. They thought she provided accurate, truthful information about the children's behaviors and the origins of their injuries.

This confidence in Ms. DeLeon had a significant impact on the assessment of all the events that occurred in her home. Some department and school staff did express concern about Tyler's injuries. However, those concerns were mitigated or dismissed when doctors and other professionals who worked closely with the family saw no basis for them.

Ms. DeLeon told professionals that Tyler's birth history and family of origin caused his reported behaviors. Her accounts of Tyler's history are not supported by the facts. The misinformation provided by Ms. DeLeon set the groundwork for others to minimize or ignore the fact that Tyler's growth declined over the last four years of his life. When he died on his seventh birthday, Tyler weighed just 28 pounds, well below the fifth percentile for a child his age. When he was placed in Ms. DeLeon's care, at age five months, Tyler weighed 16 pounds; he was within the 50<sup>th</sup> percentile for height and weight. Tyler was seen frequently by doctors, none of whom expressed concern that he was the victim of abuse or neglect.

Ms. DeLeon reported that Tyler had severe behavioral dysfunctions, including excessive water and food consumption. Ms. DeLeon told school officials that Tyler's physicians had directed her to monitor and restrict Tyler's food and fluid intake. She directed the school to restrict his food and fluid intake as well. None of these behaviors were observed by school officials, but they did not believe they were in a position to question medical professionals. DLR/CPS social workers, who investigated referrals regarding injuries in the DeLeon home prior to Tyler's death, consulted with medical professionals about the injuries. They were unable to substantiate any physical abuse by Ms. DeLeon or Ms. Burns (who provided child care for the children in Ms. DeLeon's home, when Ms. DeLeon was at work). After Tyler died, the investigation revealed that he had had a significant pattern of suspicious injuries throughout his life. The injuries were documented in medical, school and department records. He had numerous injuries that were noted by different agencies or providers, but no agency or provider was aware of the cumulative number and nature of his injuries until after his death. Medical records contained reports of injuries that were not reported to CPS or law enforcement, presumably because abuse was not suspected.

In reviewing this case, the committee focused on the fact that all the systems involved with Tyler, as well as other children in Ms. DeLeon's home, did not detect the pattern of abuse and neglect that became evident in the investigation following Tyler's death. The committee identified various issues for review.

## Issues Reviewed

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### Information Management and Retrieval

After Tyler died, the department's investigation revealed that, in 1988, Ms. DeLeon had two founded incidents of child abuse against a foster child and her two biological sons. This information was not readily evident in CA's Case and Management Information System (CAMIS) because the incidents occurred prior to the development of the electronic database in 1990. When CA transitioned to the electronic system in 1990, names of families with CA history were entered, but details of the activity remained in physical records. The existence of Ms. DeLeon's name and a case number that specifically reflected out-of-home placement of one of her children in 1988 was available, but was not easily recognizable. Further research revealed that both of Ms. DeLeon's sons were removed from her care in 1988.

When Ms. DeLeon applied for a foster home license in 1996, the case number should have alerted CA staff that Ms. DeLeon's children may have been placed out of the home. The presence of the case number in CAMIS should have prompted further investigation before Ms. DeLeon became a licensed foster parent. Several barriers were present which would have prevented further investigation regarding the previous placement and case activity.

The Department of Social and Health Services is required by statute to have a records retention policy defining how long certain categories of records should be retained before they may be destroyed. The current retention schedule for records regarding founded investigations of child abuse and neglect is that they be retained for six years after the case is closed. By the time Ms. DeLeon applied for a foster care license in 1996, the physical records from the 1988 CPS investigations regarding her foster child and biological sons were no longer retained by the department. Presumably, they were destroyed pursuant to the records retention schedule. The existence of the case number in the electronic system was the only indication that Ms. DeLeon had previous CPS history.

CA has an inefficient data system that is in need of replacement. Currently, the CAMIS system interfaces with a secondary Graphic User Interface (GUI) system. Each system maintains different sets of information on the same family depending on the year of the case activity. The GUI system was set up in the late 1990s and newer staff are more familiar with it than the CAMIS program. The licensing module has not been developed in GUI. Staff must access both systems for complete information about people and events related to licensed facilities.

Current licensing rules only allow the department to review reports of child abuse and neglect, pending criminal charges and past conviction history for prospective foster parents.<sup>1</sup> DLR and DCFS CPS social workers do not have online access to other management information systems, such as those of the juvenile and superior courts and those used for nationwide criminal background checks, which could provide more thorough information about people with whom the department is involved. These systems had information about Ms. DeLeon's 1988 CPS history. Court documents found during the fatality investigation included at least two law enforcement responses (also in 1988) to Ms. DeLeon's home for domestic disturbances

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<sup>1</sup> WAC 388-06-0150

involving her biological children. If the licensor had access to this information in 1996, the details would have disqualified Ms. DeLeon from providing licensed foster care.

### **Information Sharing and Collaboration**

While many professionals were involved in the DeLeon case, few questioned Ms. DeLeon about the validity of the information that she reported. Throughout Tyler's life, Ms. DeLeon misrepresented his behaviors and gave different information to professionals in different milieus. What she reported to the school differed from information she presented to his medical providers, which was also different from statements she gave to DLR and DCFS staff.

The department engages Child Protective Teams (CPT) to review and make recommendations about cases that are contentious or assessed to be high risk. These teams consist of community partners from professions that provide services to abused and neglected children and their families. DLR/CPS requested a CPT review of a 2004 investigation alleging physical abuse of children in the DeLeon home. The DeLeon family pediatrician was a standing member of the CPT and was present. The information presented in the staffing did not reveal the inconsistencies in Ms. DeLeon's reports about the children in her home due to the fact that some of the professionals involved in the case were not present. Department policy was followed when the case was staffed. Professionals involved with the case did not discover the contradictions in Ms. DeLeon's accounts about Tyler's behaviors, which may have invalidated her statements.

Throughout Tyler's life, Ms. DeLeon told professionals that he was a drug affected infant. Even his death certificate notes that he was drug affected at birth. The department does not know where the coroner's office obtained this information. There is no indication that Tyler was subjected to any neonatal drug use; in fact, he had a negative toxicology screen at birth. This myth was perpetuated by Ms. DeLeon for Tyler's entire life and no one questioned it, despite the absence of any source document confirming the diagnosis. Ms. DeLeon used the "fact" that Tyler was drug affected at birth to explain his multiple injuries. It became the basis for many medical and psychological interventions in Tyler's life. Professionals did not communicate with each other to compare Ms. DeLeon's stories about Tyler or question her reports that did not seem to make sense.

In addition, Ms. DeLeon failed to inform the department about significant incidents that occurred in her home, including child injuries and placement activities. Minimum licensing requirements require foster parents to notify CA about these incidents. Ms. DeLeon's failure to be forthcoming reflects a pattern of deception which began when she failed to indicate on her initial foster care license application that she had prior involvement with CPS.

### **Training**

The committee found that CA staff need training regarding critical thinking and analysis as well as confirmatory bias (the desire to identify data that supports an initially developed hypothesis), which hindered their ability to carry out their duties in the most objective manner possible. Frequently, information provided by Ms. DeLeon was not questioned, even when it appeared

confusing. Professionals continually commented on her credibility, articulation and knowledge without considering her ability to deceive or misrepresent. This case illuminates a common bias among helping professionals: if a parent presents well, it is less likely the self-report information will be questioned. Confirmatory bias was pervasive throughout the case.

## **Practice Issues**

In this case, there were a number of social work practice issues that are already addressed in policy:

- When allegations are investigated, children should be interviewed in a safe neutral setting. In this case, there were instances when the children were interviewed in the home with the caretaker present. This not only inhibits children from disclosing incidents of abuse and neglect, but indicates an element of bias in an investigation.
- In the DeLeon case, some of the children's statements were ignored due to explanations given by the adoptive mother, which were not disputed by the family's doctors. The DLR/CPS investigators consulted with physicians familiar with the family, who had a confirmatory bias. While physicians who provide treatment to a child or family are essential sources of primary or collateral information in an investigation, social workers should consult with medical consultants who do not serve the family whenever such additional consultation is needed in order to avoid conflicts of interest for medical providers.
- Social workers are mandatory reporters; they are required to report any information about child injuries or conditions that may be the result of abuse or neglect to a CPS intake social worker. Ms. DeLeon should have reported Tyler's broken leg to CPS intake or her licensor. Instead she reported to his social worker. The social worker should have reported this information to CPS intake, where a referral would have been generated requiring a DLR/CPS investigation. The licensor learned of Tyler's broken leg several months after it occurred; she made the referral to CPS intake when it came to her attention.
- When DLR/CPS investigates an allegation in a foster home and finds that it does not rise to the level of abuse and/or neglect, it should be investigated by the home licensor for potential violations of the minimum licensing requirements. This was not consistent practice in the DeLeon case.
- Information sharing and collaboration in this case failed to address critical events and inconsistencies about the care of children in the DeLeon home.

## Case Summary

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Tyler DeLeon died in the home of his adoptive mother, Carole DeLeon, on January 13, 2005 on his seventh birthday. The medical examiner determined that the cause of Tyler's death was "severe dehydration." He weighed 28 pounds, significantly below the fifth percentile for children his age.

Tyler was born on January 13, 1998. He was placed in foster care on April 5, 1998 due to concerns of neglect by his biological mother. His biological father is a registered sex offender. Although the department had concerns about Tyler's biological mother's drug use, Tyler's birth records indicate that he did not have drugs in his system at birth.

He was placed in Ms. DeLeon's home on May 29, 1998, after a brief stay in another foster home. Tyler's medical records indicate that he weighed 16 pounds on July 7, 1998, in the 50<sup>th</sup> percentile for children his age. Tyler's biological mother relinquished her parental rights on December 3, 1998. She agreed to an open adoption with Ms. DeLeon. Ms. DeLeon adopted Tyler on April 10, 2000.

Children's Administration (CA) Division of Licensed Resources Child Abuse and Neglect Section (DLR/CPS) investigated the circumstances surrounding Tyler's death in conjunction with Stevens County Sheriff's office.

Stevens County Sheriff's records (found in court files after Tyler's death) indicate that when Ms. DeLeon moved to Stevens County, Washington from Wyoming in December of 1987, she was a licensed foster parent through Casey Family Partners in Cheyenne, Wyoming. When she moved to Washington, she was accompanied by her 11-year-old daughter and a 12-year-old foster child. The investigation revealed that in 1988 Ms. DeLeon was the subject of founded allegations of abuse and neglect against a foster child and her own biological sons. Ms. DeLeon has a biological daughter, Christina, who was never alleged to be the victim of child abuse or neglect.

On April 22, 1988, the Stevens County Sheriff's office responded to a call alleging physical abuse and neglect by Ms. DeLeon and her live-in boyfriend against the 12-year-old foster child. The foster child had injuries and bruises to her upper lip, face, wrists, buttocks, eyes and thighs. She reported that she was regularly deprived of food and that the injuries around her wrists occurred when she was tied up for more than eight hours after three string cheese wrappers were found in the garbage. The physician who saw her noted that the injuries were consistent with being bound and that she appeared malnourished; he stated, "This child in my opinion does show definite signs of abuse." The foster child was removed from the home by law enforcement, and the department returned the child to foster care in Wyoming. CPS investigated these allegations in 1988. The assigned worker in 1988 continues to work for the department and recalls the allegations of child abuse were founded. However, the records from this investigation were not retained pursuant to DSHS' record retention schedule.

On June 18, 1988, Ms. DeLeon brought her two biological sons (aged 14 and 15) to Washington from Wyoming. Court files indicate there were at least two reports of domestic violence in the DeLeon home between June and July of 1988. Both reports indicated that Ms. DeLeon's sons had been beaten by Ms. DeLeon or her boyfriend. The Sheriff's report indicates that "if things

remain the same and the boys go back into the home, the possibility for serious injury or death to one of the family members is very high.” The boys were removed from the home, and they filed an Alternative Residential Placement petition with juvenile court. The boys went to visit family in Wyoming in December 1988, and never returned to Washington.

There were no convictions as a result of the domestic disturbance reports or the abuse and neglect of Ms. DeLeon’s foster child and biological sons. Ms. DeLeon’s biological daughter remained in the home. The court files indicate that CPS investigated the incidents. The records from the 1988 CPS investigations were not retained pursuant to DSHS’ record retention schedule. The CPS investigator who investigated the 1988 allegations of child abuse and neglect by Ms. DeLeon against the foster child and her own children was contacted following Tyler’s death. She said the allegations in both cases were founded for abuse.

On June 17, 1996, a private agency licensed Ms. DeLeon to provide foster care in Washington State. She indicated on her application that she had not previously been a licensed foster parent, and she had never had a child removed from her home due to court action or CPS involvement. CA’s computer database, CAMIS, had no detailed documentation of the 1988 investigations. There was a case number for one of her biological sons, but there was no information in CAMIS associated with that case number. The Sheriff’s responses to the home did not appear on the criminal background checks submitted by CA.

On May 12, 1998, Ms. DeLeon’s foster care license was transferred from Spokane Consultants to CA Division of Licensed Resources (DLR) at her request. Licensed foster parents are required to reapply for licensure every three years. None of Ms. DeLeon’s licensing applications from 1996 to 2005 indicated that she had been a foster parent prior to 1996 or that she had ever had a child removed from her home due to court action or CPS involvement.

While in Ms. DeLeon’s home, Tyler was identified as the alleged victim of child abuse and/or negligent treatment in five referrals. There were three additional referrals alleging child abuse and/or neglect of other children in Ms. DeLeon’s home while Tyler lived there. Ms. DeLeon’s biological daughter, Christina Burns, provided child care for the children living in Ms. DeLeon’s home. Interviews with the children indicate that Ms. Burns watched the children in Ms. DeLeon’s home and in her own home. Ms. Burns has two children of her own.

A review of Tyler’s school and medical records following his death reveal he had numerous injuries that were described as accidental. **Unless noted, referrals regarding these injuries were not made to CPS.**

On January 19, 1999, Tyler (age 12 months) was treated at a local clinic for a lacerated finger. Ms. DeLeon told the pediatrician the injury occurred when a wooden door slammed on his hand. She told Tyler’s adoption worker the injury was caused by a car door slamming on his hand.

On May 10, 1999, Tyler (age 17 months) was seen by his pediatrician for a spiral fracture of his femur. Ms. DeLeon reported that Tyler flung himself backward and hit his head on the refrigerator. The injury was seen by two pediatricians and an orthopedic physician; all agreed that Tyler’s injuries did not appear to be the result of abuse. Ms. DeLeon told the physicians that

Tyler was a “meth baby” and he “shakes a lot.” There is no indication in the record that Tyler was exposed to methamphetamines or any other drugs in utero. Tyler’s pediatrician’s notes indicate “bruises all over Tyler’s body, but none consistent with abuse.” This incident was reported to CPS intake on July 12, 1999 by the child’s social worker when Ms. DeLeon told her about the injury. It was screened as a licensing-only referral, to be investigated by the foster care licensur. On September 13, 1999, the licensur made a second referral regarding the same incident that screened in for a DLR/CPS investigation. The allegation was closed as unfounded because three physicians agreed that the injury did not appear to be caused by abuse.

On July 27, 1999, Tyler (age 19 months) fell on his sippy cup and knocked out his two front teeth. This incident occurred in the home of another foster parent, who confirmed that Tyler lost his two front teeth after falling on the sippy cup.

On December 26, 1999, Tyler (age 23 months) was taken to a local hospital after falling from a moving van. No injuries were indicated.

On March 28, 2001, Tyler’s pediatrician and another physician saw Tyler (age 3 years) for tantrums and head banging. He had multiple bald spots and bruises. Ms. DeLeon told the doctors that the injuries were self-inflicted. A bone age assessment showed that Tyler was two standard deviations below normal. Ms. DeLeon said that Tyler had a “superb appetite.”

On August 4, 2001, Tyler (age 3.5 years) was seen at a local clinic for cold symptoms. The physician noted that Tyler had a bite mark on his right arm that was “apparently self inflicted.”

On August 17, 2001, a physician treated Tyler for a laceration on his nose that required two sutures. It was reported that Tyler fell at the home of Ms. Burns.

On September 6, 2001, Tyler was seen by a physician regarding his short stature. Ms. DeLeon told the physician that Tyler had been failure to thrive when he was removed from his biological home. The physician noted that Tyler “does have multiple scars, scratches, and bruises in various stages of healing and has two teeth knocked out.”

On January 7, 2002, Tyler (age 4 years) saw a physician about a cold. The physician noted that there was dried blood on Tyler’s ear with no evidence of infection. During the investigation following Tyler’s death, a family friend stated that Ms. DeLeon told her that Tyler was sticking things in his ears, making them bleed, “What she did not know was that her son...had just told me that his mom had hit Tyler and knocked him off the chair at the breakfast table.”

On August 2, 2002, Tyler (age 4.5 years) was taken to the emergency room for a laceration to the bridge of his nose and a small hematoma over his right eyebrow because he “bumped his head.”

On September 16, 2002, Tyler told school staff that Ms. DeLeon pushed him for trying to call the parent of another foster child.

On September 26, 2002, Tyler had a bump over his left eye. He told school staff that Ms. DeLeon pushed him because “I was messing around in my bed.”

On October 7, 2002, Tyler had a scab on his forehead and nose. He told school staff Ms. DeLeon and Ms. Burns pushed him down the stairs. Ms. DeLeon emailed the school a message claiming that Tyler's adoptive brother had pushed him down the stairs.

On October 24, 2002, Ms. DeLeon told a physician that Tyler pulled his own hair, drank from the toilet, bit his arm, tore books, tore clothes, and banged his head against objects.

On October 24, 2002, Ms. DeLeon told school staff she tied Tyler's hands behind his back because he was pulling stitches out. On November 8, 2002, the school staff made a referral regarding Ms. DeLeon restraining Tyler.

On October 25, 2002, Ms. DeLeon told Tyler's psychiatrist that Tyler was having problems with eating and smearing his own feces, lying, stealing, and an extended tummy from eating too much. He was refusing to go to the bathroom and drinking from the toilet. The psychiatrist's records report that Tyler was eating well, but he was not gaining weight.

In November 2002, a psychologist evaluated Tyler finding that Tyler's mother and his teachers rated his behavior very differently. Although both at home and at school he exhibited signs of emotional dysregulation, "teachers rated Tyler quite low, his mother rated him quite high." The psychologist indicated that Tyler might have a disorder in the spectrum of pervasive developmental disorder.

On November 5, 2002, Ms. DeLeon told school staff at Lake Spokane Elementary, "I'm going to kill him," because Tyler was smearing feces.

On November 6, 2002, Tyler arrived at elementary school with two bruises on his back and a bruise on his head that he said were the result of falling in the bathtub and falling against a dresser. On November 8, 2002, the school staff made a referral regarding Tyler's injuries:

"... Tyler comes to school with bruises all over him and had stitches a while ago. He has a cut on his head that he says he got when mom pushed him, then he said he fell into a dresser and he said his brother ... had hit him with a wooden block. Children ... all talk about Mom hitting and kicking them. Mom said she had to tie Tyler's hands behind back so he wouldn't tear out his stitches. Tyler has started smearing feces and Mom has said that he will have to go if he keeps this up. Mom has also allegedly found Tyler with his own finger up his rectum." A foster child "has talked about being hit with a red stick which was verified by the other two boys who say they get hit with it as well."

The referral was investigated by DLR/CPS. When Tyler was interviewed, he said Ms. DeLeon spanked him with a stick, and she had also pushed him. Tyler had an unexplained two inch linear bruise on his leg. His adopted brother said Tyler is sent to bed without supper for soiling his pants.

Ms. Burns said she sometimes disciplines the children by withholding drinks. She said Tyler smacks his head into walls, falls onto the floor, and smacks himself in the head. Ms. Burns

reported that Tyler has a high threshold for pain. Ms. DeLeon told the DLR/CPS investigator she tied Tyler's hands in order to prevent him from pulling out stitches in his mouth. She said that he drank excessively from the toilet, and drank toilet water after urinating and defecating into the toilet. Ms. DeLeon said Tyler had a high tolerance for pain, fell down often, banged his head, bit himself, and smeared feces.

Tyler's psychiatrist told the DLR/CPS investigator that she frequently sees bruising on Tyler. She felt that Ms. DeLeon was appropriate and that tying his hands to keep him from pulling out stitches was understandable, since developmentally delayed children sometimes need to be restrained.

On January 15, 2003, the DLR/CPS investigation was closed as unfounded. The licensing complaint was closed as not valid for licensing concerns.

On January 16, 2003, Ms. DeLeon told school staff that Tyler's psychiatrist told her that Tyler (age 5 years) "will make up stories" and that it would be best to ignore him because his injuries were self-inflicted.

On January 27, 2003, Ms. DeLeon reported to the school that Tyler would not be at school because he made a "big mess" with feces.

On January 30, 2003, Tyler arrived at school with a one inch bruise on his face. He said he fell against his bed, but later said that he fell against the wall.

On June 27, 2003, Ms. DeLeon talked with Tyler's psychiatrist about her plans to leave Tyler (age 5.5 years) in respite care while the rest of the family went to Disneyland.

On August 17, 2003, Ms. DeLeon told Tyler's psychiatrist that Tyler gained seven pounds in respite care because he "ate non-stop." There is no record of where Ms. DeLeon placed Tyler when the family went on vacation.

On October 20, 2003, Tyler arrived at school with bruises on his nose and a cut to his lip. Ms. DeLeon told school staff that Tyler fought with a foster child.

On November 24, 2003, a foster child in the DeLeon home told school staff that he did not like Ms. Burns because she "smacks" him, Tyler, and another adopted child.

On December 5, 2003, Ms. DeLeon told Tyler's psychiatrist that Tyler's stomach was distended from drinking too much and that he ate to the point of vomiting.

On December 5, 2003, Ms. DeLeon told school staff that Tyler was going to receive "sensory integration" therapy for an eating and drinking disorder. No evidence that Tyler was diagnosed with an eating or drinking disorder or that this therapy had been recommended could be found by DLR/CPS investigators after Tyler's death.

On January 30, 2004, Ms. DeLeon told Tyler's psychiatrist that Tyler (age 6 years) needed to be accompanied to the bathroom to keep him from drinking toilet water.

On March 22, 2004, Tyler arrived at school with "serious bruising" to his forehead. He stated that he did not remember how it happened.

On April 21, 2004, Tyler arrived at school with bruising on each of his cheeks and on the bridge of his nose. He also had a 1.5 inch mark on his side. He told three people that the bruise was the result of being "kicked" down the stairs by Ms. Burns. A foster child verified Tyler's explanation when school staff interviewed him. School staff made a referral to CPS. It was investigated by DLR/CPS.

On April 22, 2004, Tyler told the DLR/CPS investigator that Ms. Burns pushed him down the stairs.

On April 23, 2004, school personnel provided DLR/CPS a typed note about a conversation between school staff and Ms. DeLeon. Ms. DeLeon told school staff that she was seeking medical/psychological help for Tyler and "if I ever started beating him he would be dead, because I wouldn't be able to stop." She also said, while discussing Tyler's feces smearing, "I want to beat the ever-loving daylights out of him. But him being covered in shit is the saving grace, otherwise, I probably would beat the shit out of him." She requested that school staff ignore him if he tells them that he has been abused.

The referral from April 21, 2004 was closed as unfounded for physical abuse because the investigator felt that Tyler's statements were not credible. The licenser determined that the licensing complaint was not valid.

On June 8, 2004, Ms. DeLeon gave the school a three-page typed letter admonishing school staff for calling CPS and for not supervising Tyler (age 6.5 years) and a foster child (age 7 years) more closely when they go to the bathroom, where she believed they were drinking excessive amounts of water. She wrote, "Their bellies were so bloated they looked like they were going to pop. EVERY SINGLE DAY!" Ms. DeLeon also wrote, "Just yesterday the doctor was emphasizing how life threatening the eating/drinking disorder can be." Tyler and the foster child's medical records have been extensively reviewed and there are no notes indicating that drinking excessive amounts of water could be life threatening to these children. There are no independent observations to corroborate Ms. DeLeon's statements that they drank excessive amounts of water.

On June 25, 2004, Ms. DeLeon took Tyler to see his pediatrician. The pediatrician's notes indicate that Ms. DeLeon was frustrated because the family had recently gone to the lake. Tyler started screaming and saying he was thirsty and he "screamed and screamed and screamed" attracting attention to himself. The pediatrician wrote that Tyler was telling school staff that he was being kicked down the stairs. Ms. DeLeon reported that Tyler was smearing feces frequently and that she felt it was calculated and done "much more to the level of get-backs for behavior when she does things he doesn't like." The pediatrician's notes indicated that Tyler's defiance was much worse, and Ms. DeLeon had considered sending him to inpatient residential

treatment. The pediatrician referred Tyler to a counselor for attachment therapy. Ms. DeLeon was referred for individual counseling.

On June 25, 2004, school district professionals received a letter from Tyler's psychiatrist, addressed "To Whom It May Concern" about Tyler regarding his reactive-attachment disorder:

"This is a severe behavioral and relational disorder in which the child seeks negative attention from his caregivers by engaging in often outrageous, loud, and upsetting behavior. Caregivers must often respond to their behavior by ignoring it. Although this may seem alarming to bystanders, responding to this type of behavior with anything but indifference or a calculated calm discipline only reinforces it. This only prolongs the time it will take to extinguish this bizarre and upsetting behavior, and interferes with the child establishing prosocial behavior."

Ms. DeLeon placed copies of this letter on the windshields of cars belonging to school staff.

On October 20, 2004, Tyler's counselor's treatment plan noted concerns about Ms. DeLeon's attachment to Tyler and his behavioral problems. She wrote that Tyler had problems limiting his food and water intake. Concerns included "drinking the toilet water, drink(ing) until he is bloated or eat(ing) until he gets ill." He "smeared feces when he did something enjoyable such as participate in a party... He lacked reciprocal enjoyment, eye contact, empathy, guilt, emotional communication, and other attachment related traits. He was oppositional defiant, excessively controlling, lied, excused, blamed, was destructive, stole, hoarded, manipulated, had a sense of entitlement and responded poorly to discipline." The therapist indicated Tyler needed mental health services for reactive-attachment disorder. She expressed concern for Ms. DeLeon because she was "experiencing burn out and tends to be angry and emotionally shut down to him (Tyler)."

On January 4, 2005, CPS received a referral from the school. Tyler had bruises under each eye and on the bridge of his nose. Tyler said he fell down the stairs and Ms. DeLeon reported that he threw a three-hour temper tantrum on the stairs. The referral was assigned to DLR/CPS for investigation of neglect related to allowing a child to tantrum three hours on the stairs. The case was still open for investigation when Tyler died on January 13, 2005.

On January 14, 2005, a referral was made to CPS by the Spokane County Medical Examiner's office regarding Tyler's death on January 13, 2005. The referral was assigned to DLR/CPS for investigation.

There were five adopted children (including Tyler) and an infant foster child living in Ms. DeLeon's home when Tyler died.

On January 14, 2005, DLR/CPS recommended DCFS remove infant foster child from the home. He was removed on this date.

On March 23, 2005, CA removed Ms. DeLeon's adopted children due to mounting evidence that Ms. DeLeon and Ms. Burns had regularly withheld food and water from Tyler and other children in the home.

On October 14, 2005, DLR/CPS closed the January 2005 referrals regarding Tyler's death and the bruises on his face. They were founded for physical abuse and negligent treatment. The investigation found that Ms. DeLeon and Ms. Burns consistently severely limited Tyler's food and water intake throughout his life. The documentation also indicates that Ms. DeLeon was skilled in misleading professionals (physician, therapist, social workers, psychiatrist and school personnel) regarding Tyler's behaviors and medical conditions and diagnosis.

According to school staff, Ms. DeLeon told them Tyler had an eating/drinking disorder that required adults to restrict his food and fluid consumption. The DLR/CPS investigator could not find any medical records to support Ms. DeLeon's statements to school staff about the need to restrict Tyler's diet.

According to school staff, Tyler did not appear to have flu symptoms on January 11, 2005, his last day of school. Dr. Naomi Sugar, a pediatrician who specializes in child abuse and neglect cases, reviewed all of Tyler's medical records after his death at the request of DLR/CPS. According to Dr. Sugar, "Dehydration of up to 10% of body weight is not unusual, and would not in itself be a cause of death." She also wrote, "It is extraordinarily rare for children out of infancy to die of dehydration in the United States."

Ms. DeLeon and Ms. Burns isolated Tyler in his bedroom for long periods of time. They locked him in his bedroom, used door locks and monitors and turned off the water supply to the basement bathroom so he could not drink.

Other children, both foster and adopted, who have been removed from the DeLeon home, have described Ms. DeLeon as a caretaker who withheld food as a punishment. A 12-year-old foster child who weighed 176 pounds when she was placed in Ms. DeLeon's home lost 72 pounds in less than a year. Another seven-year-old foster child, whom Ms. DeLeon described as having similar eating and drinking disorders as Tyler, weighed 34 pounds (below the fifth percentile) when he left the DeLeon home. He has gained 36 pounds in the ten months since he left her home. Tyler's adopted sister also dropped to below the fifth percentile in Ms. DeLeon's home. She has gained five pounds since she was removed.

In the eleven months since Tyler's death, there have been six new referrals alleging physical abuse, negligent or maltreatment of other children who were placed in the DeLeon home prior to Tyler's death. Several of Tyler's adopted and foster siblings have reported that Ms. DeLeon and Ms. Burns physically abused them and withheld food and water from them. These referrals were generated both by DSHS staff and providers upon learning of new allegations of abuse and neglect in the course of the investigation following Tyler's death.

## Findings and Recommendations

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The committee makes the following findings and recommendations based on interviews, review of case records and department policy and protocol, Revised Code of Washington (RCW) and Washington Administrative Code (WAC), contracts, and certification documents.

CA encompasses DCFS, DLR/CPS and Foster Care Licensing. The findings and recommendations address both DCFS and DLR.

### Fatality Review Process

#### *Recommendations:*

1. This report should be made available and disseminated to department employees and stakeholders connected to this case. The report should be made easily accessible to others who are interested in this case.
2. The committee requests that the department provide a response to the committee regarding the recommendations in this report.

### Information Management and Retrieval

#### *Findings:*

DSHS record retention policies compromise social workers' access to accurate history of cases. Each state agency is required by statute to establish a policy regarding retention and destruction of records. Current DSHS policy requires that CA retain the records of founded child abuse and neglect investigations for six years after a case is closed. Ms. DeLeon's founded records from 1988 were not available when she was licensed in 1996. In this case, if there had been adequate knowledge of a record in 1988 pertaining to Ms. DeLeon's children and her involvement with Stevens County Sheriff's Department and CA, she would not have been eligible for a foster care license per **WAC 388-148-0035 (4)**:

***What personal characteristics do I need to provide care to children?** If you are requesting a license, certification, or a position as an employee, volunteer, intern, or contractor in a foster home, group care facility, staffed residential home, or child-placing agency you must have the following specific personal characteristics:*

*(4) You must not have been found to have committed abuse or neglect of a child or vulnerable adult, unless the department determines that you do not pose a risk to a child's safety, well being, and long-term stability.*

- Social workers' capacity to thoroughly investigate may have been compromised by their inability to access pertinent information which was kept in other data base systems such as JUVIS (Juvenile Court Information System), Courtlink (U.S. District Court and state court information), SCOMIS (Superior Court Management Information System) and NCIC (National Crime Information Center).

- Lack of uniformity with the way information was referenced in the CAMIS and GUI databases interfered with the efficacy of the investigation. Lack of integrated case numbers and information resulted in misinterpretation of information regarding the involvement of Ms. DeLeon and her sons in the system in 1988.

The application of CA's background check process is inconsistent and lacks uniformity. There is a discrepancy in training made available to staff who review CAMIS records for licensing applicants.

*Recommendations:*

1. The department should extend the timeline regarding retention of records on founded child abuse and neglect investigations. The department should review their current retention schedule to determine an appropriate extension of the time period.
2. The department should address ways to provide CA staff access to the JUVIS, SCOMIS, Courtlink and NCIC systems.
3. The department should integrate the CAMIS/GUI systems in order to provide more efficient and complete information gathering.
4. Establish a clear and consistent procedure for more thorough background investigation. Adequate training should be provided to staff performing this task.
5. The department should require a consistent application of case number assignment statewide.

**Information Sharing and Collaboration**

*Findings:*

- Service providers, including the school district and medical community, were operating from different sets of information. Relying exclusively on self reports by Ms. DeLeon, little or no verification of facts was confirmed.
- Ms. DeLeon failed to report a number of Tyler's injuries in a timely manner.
- Ms. DeLeon failed to inform her licensor that she adopted an infant from a source unknown to the department.
- Ms. DeLeon failed to report previous involvement with the department on her original and subsequent licensing documents.
- Tyler was seen by multiple medical providers for physical and psychological health care amongst whom there was no sharing of information.

- There were discrepancies in reporting incidents to service providers by Ms. DeLeon. When these discrepancies were discovered, there was no mechanism to resolve them. For example, Ms. DeLeon reported to the school that the medical provider had recommended restriction of Tyler’s fluids and caloric intake. In the process of the investigation, it was determined that the doctor made no such recommendation. The school indicated to the committee that they felt there was no mechanism by which to confirm this with the doctor.

#### *Recommendations:*

1. CA should research the concept of “health care management”<sup>2</sup> in order to develop a practice standard to facilitate the open exchange of information with all providers. Each service provider should have access to multiple sources of information to avoid triangulation and miscommunication.
2. CA should explore the use of the Foster Care Medical Home Model<sup>3</sup> as described in *Fostering Health: Health Care for Children and adolescents in Foster Care*.
3. CA should request legislation to change RCW 68.50.105 to allow CA access to reports and records of autopsies or post mortems.

#### **Training**

#### *Findings:*

- CA did not recognize the sophistication with which Ms. DeLeon was managing information.
- Confirmatory bias was prevalent throughout the case. Professionals from all systems locked into early opinions based on information Ms. DeLeon reported, and disregarded information contrary to their initial impressions.

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<sup>2</sup> “Health care management” is a set of functions to ensure that children in foster care receive high quality, comprehensive, and coordinated health care. This is an effort that strives to coordinate the traditional caseworker role of overseeing health care with other professional and medical roles such that neither operates in a vacuum. To this end this coordination includes systematic communication between all professionals involved in the lives of the children. This concept of health care management is described in detail in the AAP publication, *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2<sup>nd</sup> edition, written by the Task Force on Health Care for Children in Foster Care, AAP District II, New York State, 2005, pgs 77-89.

<sup>3</sup> This model provides that “children and adolescents in foster care receive their medical care in a primary care setting staffed by pediatric health care professionals who understand the effect of foster care on children and families, are familiar with the regulations and mandates of child welfare, and have experience in child abuse and neglect. In addition....(they) must be willing to work in collaborative cooperative partnership with child welfare personnel, foster and birth parents, and multiple other professionals ( in this case educators) on behalf of these children and families” *Fostering Health*, 2<sup>nd</sup> Edition, Task Force on Health Care for Children in Foster Care, American Academy of pediatrics, District II, New York State, 2005, pg 14.

- Information regarding reported diagnoses with no factual base perpetuated erroneous beliefs about Tyler's behaviors. The record contained statements made about diagnoses that were not supported by source documents. Behavioral observations of Tyler by educators disputed reports supplied by Ms. DeLeon.
- There were indications of parental ambivalence by Ms. DeLeon which included repeated utterance of denigrating statements made about Tyler and the other children in the home.
- There was a pattern of events in which not one individual incident substantiated a level of verified child abuse and/or neglect. In the aggregate, these gave rise to an elevated risk that should have resulted in further action from the department.
- Environmental failure to thrive was apparent. Emotional and nutritional neglect resulting in poor growth is difficult to recognize, even by trained professionals.

*Recommendations:*

1. CA staff should continue to emphasize training to recognize its own confirmatory bias as well as confirmatory bias evident in the assessments of other professionals.
2. CA should continue to provide training in critical thinking.
3. The department should provide an opportunity for community partners to participate in CA training.
4. The department should incorporate training on parental ambivalence and pattern recognition in cases of child abuse and/or neglect on a regular basis.
5. The department should develop a chronicity review protocol to include DLR/CPS and adoption workers.
6. CA staff should be trained in the use of the department's proposed health management model to assist with communication among professionals.

**Practice Issues**

*Findings:*

- Children should not have been interviewed in the presence of the alleged perpetrator.
- Independent licensing investigations should have followed the CPS investigation when the allegation was unfounded.
- The child's statements disclosing abuse were ignored.

- Mandatory reporters did not recognize signs of abuse or neglect and, therefore, did not make reports to the department.
- There was insufficient collaboration and information sharing amongst service providers and the department.

*Recommendations:*

Some of these findings are already addressed in CA policy. Although the committee did not have any recommendations regarding these findings, they believed they had a significant impact on this case.

## Bibliography

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*Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2<sup>nd</sup> edition, written by the Task Force on Health Care for Children in Foster Care, AAP District II, New York State, 2005

Greenberg, S. A., Shuman, D.W., Irreconcilable Conflict Between Therapeutic and Forensic Roles (1997). *Professional Psychology: Research and Practice*, 28, 50-57

Larsen: Social Dwarfism, Williams Textbook of Endocrinology, 10<sup>th</sup> ed., Copyright 2003 Elsevier, 1050-51

Martindale, D. A. (2005). Confirmatory Bias and Confirmatory Distortion. *Journal of Child Custody: Research, Issues, and Practices*, 2:1/2\*, 33-50

Munro, E. (2005). A systems approach to investigating child abuse deaths. *British Journal of Social Work* 35, 531-46

Skuse, D., Albanese, A., Stanhope, R., Gilmour, J., Voss, L. (1996). A new stress-related syndrome of growth failure and hyperphagia in children, associated with reversibility of growth-hormone insufficiency. *Lancet*. 353-8 *National Academies Press, Children's Health, the Nation's Wealth: Assessing and Improving Child Health* (2004)